

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER ELKHART GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E BLVD ELKHART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00152848</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date: 8-13-14</p> <p>Facility Number: 005017</p> <p>Surveyor: Brian Montgomery, RN, BSN</p> <p>Elkhart General Hospital is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 09/03/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE